FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043778

Facility Name: FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK

Address: 8200 West Roosevelt Road (Number) Forest Park (City) 60130 (Zip Code)

County: Cook

Telephone Number: (708) 488-9850 **Fax #** (708) 488-9870

IDPA ID Number: 36-4186094-001

Date of Initial License for Current Owners: 3/18/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	Edward Slack, C.P.A.
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	232	Skilled (SNF)	232	84,912	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,912	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	790		6,404	7,194	8
9	SNF/PED					9
10	ICF	32,065	9,580		41,645	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,855	9,580	6,404	48,839	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.52%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 3/23/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/23/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 5,113

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION O # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	206,196	27,222	18,628	252,046		252,046	(8,722)	243,324			1
2	Food Purchase		161,979		161,979	(7,613)	154,366	4,257	158,623			2
3	Housekeeping	128,820	30,504		159,324		159,324	(1,957)	157,367			3
4	Laundry	49,883	14,891		64,774		64,774		64,774			4
5	Heat and Other Utilities			222,535	222,535		222,535	(5,066)	217,469			5
6	Maintenance	71,894		114,931	186,825		186,825	(7,141)	179,684			6
7	Other (specify):*							1,937	1,937			7
8	**TOTAL General Services**	456,793	234,596	356,094	1,047,483	(7,613)	1,039,870	(16,692)	1,023,179			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	1,913,987	117,328	306,741	2,338,056		2,338,056	1,493	2,339,549			10
10a	Therapy	76,842	2,008	11,275	90,125		90,125	(2,420)	87,705			10a
11	Activities	111,063	8,371	5,861	125,295		125,295	(2,039)	123,256			11
12	Social Services	35,892		13,281	49,173		49,173	(11,730)	37,443			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							12,583	12,583			15
16	**TOTAL Health Care and Programs**	2,137,784	127,707	367,158	2,632,649		2,632,649	(2,113)	2,630,536			16
	C. General Administration											
17	Administrative	31,500		77,684	109,184		109,184	28,142	137,326			17
18	Directors Fees											18
19	Professional Services			373,484	373,484	(27,053)	346,431	(316,417)	30,014			19
20	Dues, Fees, Subscriptions & Promotions			93,847	93,847		93,847	(42,059)	51,788			20
21	Clerical & General Office Expenses	101,296	24,093	198,868	324,257		324,257	(75,033)	249,224			21
22	Employee Benefits & Payroll Taxes			500,435	500,435	7,613	508,048	(32,119)	475,929			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,927	6,927		6,927	3,864	10,791			24
25	Other Admin. Staff Transportation			3,961	3,961		3,961	(2,911)	1,050			25
26	Insurance-Prop.Liab.Malpractice			69,975	69,975		69,975	886	70,861			26
27	Other (specify):*							22,908	22,908			27
28	**TOTAL General Administration**	132,796	24,093	1,325,181	1,482,070	(19,440)	1,462,630	(412,740)	1,049,890			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,727,373	386,396	2,048,433	5,162,202	(27,053)	5,135,149	(431,544)	4,703,605			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK
0043778
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	7,613	
2	FOOD		7,613

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	27,053	
19	PROFESSIONAL FEES		27,053

To reclass cost of appealing real estate taxes

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PAI#0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,235	23,235		23,235	712,867	736,102			30
31	Amortization of Pre-Op. & Org.							12,710	12,710			31
32	Interest			368,987	368,987		368,987	879,311	1,248,298			32
33	Real Estate Taxes			195,276	195,276	27,053	222,329	(3,811)	218,518			33
34	Rent-Facility & Grounds			1,016,160	1,016,160		1,016,160	(1,012,715)	3,445			34
35	Rent-Equipment & Vehicles			8,067	8,067		8,067	2,848	10,915			35
36	Other (specify):*											36
37	TOTAL Ownership			1,611,725	1,611,725	27,053	1,638,778	591,210	2,229,988			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	195,558	336,436	229,662	761,656		761,656	(27,351)	734,305			39
40	Barber and Beauty Shops			31	31		31		31			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,368	127,368		127,368		127,368			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	195,558	336,436	357,061	889,055		889,055	(27,351)	861,704			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,922,931	722,832	4,017,219	7,662,982		7,662,982	132,314	7,795,296			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(55)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	148,335	30		9
10	Interest and Other Investment Income	(82,420)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(314)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(14,203)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(121,226)	21		24
25	Fund Raising, Advertising and Promotional	(20,595)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,250)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,070)	20		28
29	Other-Attach Schedule	(61,869)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (154,667)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	286,981		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 286,981		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 132,314		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK

ID# 0043778

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Miscellaneous Income	(200)	21	2
3	Jury Duty Income	(17)	10	3
4	Collection Expense	(1,444)	21	4
5	Theft Loss	(1,238)	21	5
6	Prior Year Legal Fees	(220)	19	6
7	Doctor's Office - Depreciation	(13,527)	30	7
8	Doctor's Office - Utilities	(6,396)	5	8
9	Doctor's Office - RE Tax	(5,612)	33	9
10	Doctor's Office - Maintenance Salaries	(2,066)	6	10
11	Doctor's Office - Housekeeping Salaries	(3,691)	3	11
12	Doctor's Office - Mortgage Interest	(25,416)	32	12
13	Misc. Cash Receipts	(785)	21	13
14	Voided Check - Legal Fees	(940)	19	14
15	Donation	(317)	20	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(61,869)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PA # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			4,138	(8,468)		(4,392)						(8,722)	1
2	Food Purchase	(369)		(880)			5,506						4,257	2
3	Housekeeping	(3,691)		1,734									(1,957)	3
4	Laundry													4
5	Heat and Other Utilities	(6,396)		1,330									(5,066)	5
6	Maintenance	(2,066)		10,887	(15,987)		25						(7,141)	6
7	Other (specify):*			1,666			271						1,937	7
8	**TOTAL General Services**	(12,522)		18,875	(24,455)		1,410						(16,692)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)		20,999	(79,548)	69,767	4		(9,712)				1,493	10
10a	Therapy			4,056	(6,476)								(2,420)	10a
11	Activities			1,759	(3,798)								(2,039)	11
12	Social Services			1,551	(13,281)								(11,730)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,619		8,964							12,583	15
16	**TOTAL Health Care and Programs**	(17)		31,984	(103,103)	78,731	4		(9,712)				(2,113)	16
	C. General Administration													
17	Administrative			27,999	(65,489)	65,489	143						28,142	17
18	Directors Fees													18
19	Professional Services	(1,160)	1,898	7,372	(324,570)		43						(316,417)	19
20	Fees, Subscriptions & Promotions	(21,982)		1,082	(21,170)		11						(42,059)	20
21	Clerical & General Office Expenses	(140,346)	(5,000)	99,719	(29,548)		142						(75,033)	21
22	Employee Benefits & Payroll Taxes				(32,119)								(32,119)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,855			9						3,864	24
25	Other Admin. Staff Transportation			171	(3,330)		248						(2,911)	25
26	Insurance-Prop.Liab.Malpractice			886									886	26
27	Other (specify):*			14,732		8,176							22,908	27
28	**TOTAL General Administration**	(163,488)	(3,102)	155,816	(476,227)	73,665	596						(412,740)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(176,027)	(3,102)	206,675	(603,784)	152,396	2,010		(9,712)				(431,544)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PA # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	134,808	544,002	9,303						24,754			712,867	30
31	Amortization of Pre-Op. & Org.		12,710										12,710	31
32	Interest	(107,836)	969,299	10,073			9			7,766			879,311	32
33	Real Estate Taxes	(5,612)		1,801									(3,811)	33
34	Rent-Facility & Grounds		(1,016,160)	3,445									(1,012,715)	34
35	Rent-Equipment & Vehicles			2,835			13						2,848	35
36	Other (specify):*													36
37	**TOTAL Ownership**	21,360	509,851	27,457			22			32,520			591,210	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(5,691)			(21,660)			(27,351)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(5,691)			(21,660)			(27,351)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(154,667)	506,749	234,132	(603,784)	152,396	(3,659)		(9,712)	10,860			132,314	45

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Forest Park Property LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	$ 1,016,160	Forest Park Property LLC	100.00%	$	$ (1,016,160)	1
2	V	21	Title Co. Refund		Forest Park Property LLC	100.00%	(5,000)	(5,000)	2
3	V	32	Interest Expense		Forest Park Property LLC	100.00%	969,299	969,299	3
4	V	19	Architect Fees		Forest Park Property LLC	100.00%	540	540	4
5	V	19	Legal Fees		Forest Park Property LLC	100.00%	1,358	1,358	5
6	V	31	Amortization		Forest Park Property LLC	100.00%	12,710	12,710	6
7	V	30	Depreciation		Forest Park Property LLC	100.00%	544,002	544,002	7
8	V				Forest Park Property LLC	100.00%			8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,016,160			$ 1,522,909	$ * 506,749	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 4,138	$ 4,138	15
16	V	2	FOOD				(880)	(880)	16
17	V	3	HOUSEKEEPING				1,734	1,734	17
18	V	5	UTILITIES				1,330	1,330	18
19	V	6	REPAIRS AND MAINT.				10,887	10,887	19
20	V	7	EMP. BEN. - GEN. SERV.				1,666	1,666	20
21	V	10	NURSING				20,999	20,999	21
22	V	10A	THERAPY				4,056	4,056	22
23	V	11	ACTIVITIES				1,759	1,759	23
24	V	12	SOCIAL SERVICES				1,551	1,551	24
25	V	15	EMP. BEN. - HEALTHCARE				3,619	3,619	25
26	V	17	ADMINISTRATIVE				27,999	27,999	26
27	V	19	PROFESSIONAL FEES				7,372	7,372	27
28	V	20	DUES, SUBSCRIPTIONS				1,082	1,082	28
29	V	21	CLERICAL AND GENERAL				99,719	99,719	29
30	V	24	SEMINARS				3,855	3,855	30
31	V	25	AUTO EXPENSE				171	171	31
32	V	26	INSURANCE				886	886	32
33	V	27	EMP. BEN. - GEN. ADMIN.				14,732	14,732	33
34	V	30	DEPRECIATION				9,303	9,303	34
35	V	32	INTEREST				10,073	10,073	35
36	V	33	REAL ESTATE TAXES				1,801	1,801	36
37	V	34	BUILDING RENT - UNRELATED				3,445	3,445	37
38	V	35	EQUIPMENT RENTAL				2,835	2,835	38
39	Total			$			$ 234,132	$ * 234,132	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 8,468	CARE CENTERS, INC.	100.00%	$ 0	$ (8,468)	15
16	V	19	ACCOUNTING	15,000			0	(15,000)	16
17	V	19	ANCIL ADMIN FEE	27,840			0	(27,840)	17
18	V	19	BOOKEEPING	47,328			0	(47,328)	18
19	V	19	DATA PROCESSING	8,352			0	(8,352)	19
20	V	19	LEGAL	21,170			0	(21,170)	20
21	V	19	MANAGEMENT FEE	194,880			0	(194,880)	21
22	V	19	PROFESSIONAL FEES	10,000			0	(10,000)	22
23	V	20	ADVERTISING	21,170			0	(21,170)	23
24	V	25	REBILL BUS	3,330			0	(3,330)	24
25	V	0					0		25
26	V	22	HOME OFFICE PAYROLL TAX	32,119			0	(32,119)	26
27	V	1	REBILL. PAYROLL DIETARY	0			0		27
28	V	3	REBILL. PAYROLL HSKPNG	0			0		28
29	V	6	REBILL. PAYROLL MAINT.	15,987			0	(15,987)	29
30	V	10	REBILL. PAYROLL NURSING	79,548			0	(79,548)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	6,476			0	(6,476)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	3,798			0	(3,798)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	13,281			0	(13,281)	33
34	V	17	REBILL. PAYROLL ADMIN.	65,489			0	(65,489)	34
35	V	21	REBILL. PAYROLL CLERICAL	29,548			0	(29,548)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 603,784			$ 0	$ * (603,784)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 69,767	$ 69,767	15
16	V	15	EMP. BEN HEALTHCARE				8,964	8,964	16
17	V	17	ADMINISTRATIVE				65,489	65,489	17
18	V	27	EMP. BEN GEN. ADMIN.				8,176	8,176	18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 152,396	$ * 152,396	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION, INC.	100.00%	$ 2,844	$ 2,844	15
16	V	2	FOOD				5,506	5,506	16
17	V	6	MAINTENANCE				25	25	17
18	V	7	EMP. BEN. - GEN. SERV.				271	271	18
19	V	10	NURSING				4	4	19
20	V	17	ADMINISTRATIVE				143	143	20
21	V	19	PROFESSIONAL FEES				43	43	21
22	V	20	DUES, FEES, SUB.				11	11	22
23	V	21	CLERICAL & GENERAL				142	142	23
24	V	24	SEMINARS				9	9	24
25	V	25	TRAVEL				248	248	25
26	V	32	INTEREST				9	9	26
27	V	35	RENT - EQUIPMENT & VEHICLES				13	13	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				186	186	28
29	V	1	DIETARY SUPP	7,236			0	(7,236)	29
30	V	39	ANCILLARY SUPP	5,877			0	(5,877)	30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,113			$ 9,454	$ * (3,659)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	CLERICAL AND GENERAL	$	CARE CENTERS, INC.	100.00%	$ 0	$	15
16	V	27	EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0					0		17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICALSUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 51,201	$ 51,201	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICALSUPPLIES	60,913				(60,913)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,913			$ 51,201	$ * (9,712)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	VENTLEASE LLC	100.00%	$ 24,754	$ 24,754	15
16	V	32	INTEREST				7,766	7,766	16
17	V								17
18	V								18
19	V	39	ANCILLARY EQUIP RENT	21,660				(21,660)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,660			$ 32,520	$ * 10,860	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 63,727	$ 63,727	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	63,727				(63,727)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 63,727			$ 63,727	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	82.32	see attached	1.58	2.20		$		1
2	Jim Goodsite	Owner	Administrative	0.86	see attached	1.62	3.24	salary alloc.	4,204	17-7	2
3	Gordon Brown	Owner	Administrative	0.86	see attached	1.62	3.24	salary alloc.	2,055	17-7	3
4	David Aronin	Owner	Administrative	0.86	see attached	1.62	3.24	salary alloc.	2,831	17-7	4
5	Mark Steinberg	Relative	Administrative		see attached	1.62	3.24	salary alloc.	1,433	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,523		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,512,231	32	$ 128,135	$ 128,055	48,839	$ 4,138	1
2	2	FOOD	PATIENT DAYS	1,512,231	32	(27,254)		48,839	(880)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,512,231	32	53,695	52,345	48,839	1,734	3
4	5	UTILITIES	PATIENT DAYS	1,512,231	32	41,192		48,839	1,330	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,512,231	32	337,107	220,731	48,839	10,887	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,512,231	32	51,593		48,839	1,666	6
7	10	NURSING	PATIENT DAYS	1,512,231	32	650,209	657,173	48,839	20,999	7
8	10A	THERAPY	PATIENT DAYS	1,512,231	32	125,600	125,524	48,839	4,056	8
9	11	ACTIVITIES	PATIENT DAYS	1,512,231	32	54,474	54,163	48,839	1,759	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,512,231	32	48,011	48,011	48,839	1,551	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,512,231	32	112,058		48,839	3,619	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,512,231	32	866,963	862,068	48,839	27,999	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,512,231	32	228,254		48,839	7,372	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,512,231	32	33,513		48,839	1,082	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,512,231	32	3,087,659	2,709,599	48,839	99,719	15
16	24	SEMINARS	PATIENT DAYS	1,512,231	32	119,372		48,839	3,855	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,512,231	32	5,310		48,839	171	17
18	26	INSURANCE	PATIENT DAYS	1,512,231	32	27,429		48,839	886	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,512,231	32	456,163		48,839	14,732	19
20	30	DEPRECIATION	PATIENT DAYS	1,512,231	32	288,068		48,839	9,303	20
21	32	INTEREST	PATIENT DAYS	1,512,231	32	311,903		48,839	10,073	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,512,231	32	55,780		48,839	1,801	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,512,231	32	106,673		48,839	3,445	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,512,231	32	87,772		48,839	2,835	24
25	TOTALS					$ 7,249,679	$ 4,857,669		$ 234,132	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		9	307,262	298,696		69,767	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		9	39,980			8,964	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		24	1,436,904	1,436,850		65,489	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		24	191,316			8,176	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,975,462	$ 1,735,546		$ 152,396	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,287,765	28	496,134	378,284	13,113	2,844	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,287,765	28	960,501		13,113	5,506	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,287,765	28	4,392		13,113	25	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,287,765	28	47,282		13,113	271	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,287,765	28	700		13,113	4	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,287,765	28	25,000		13,113	143	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,287,765	28	7,428		13,113	43	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,287,765	28	1,836		13,113	11	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,287,765	28	24,796		13,113	142	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,287,765	28	1,526		13,113	9	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,287,765	28	43,326		13,113	248	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,287,765	28	1,489		13,113	9	12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC.	2,287,765	28	2,182		13,113	13	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,287,765	28	32,397		13,113	186	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,648,989	$ 378,284		$ 9,454	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075			1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,476	$ 31,075		$	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION			$	$		$ 51,201	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 51,201	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: VENTLEASE LLC
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT ALLOCATION			$	$		$ 24,754	1
2	32	INTEREST	DIRECT ALLOCATION						7,766	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 32,520	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 63,727	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 63,727	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION O # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Corus Bank		X	Mortgage		6/30/96	$	$ 10,434,597		Prime + 1	$ 884,325	1
2	Less allocation to Dr. office										(25,416)	2
3												3
4												4
5												5
	Working Capital											
6	Care Centers, Inc.	X		Working Capital							244,874	6
7	Diawa		X	Line of Credit				4,043,585			97,558	7
8	Shareholder Loan	X		Working Capital				50,000		0.0800	4,962	8
9	TOTAL Facility Related						$	$ 14,528,182			$ 1,206,303	9
	B. Non-Facility Related*											
10	Supplemental Schedule										41,995	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 41,995	14
15	TOTALS (line 9+line14)						$	$ 14,528,182			$ 1,248,298	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF I # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Corus Bank		X	Working Capital			$	$			$ 21,593	1
2	Interest Income										(82,420)	2
3	Pavilion of Forest Park (Bldg Co)	X									81,625	3
4	Hunter Management	X									3,349	4
5	Allocated from Care Center	X									10,082	5
6	Allocated from Ventlease LLC	X									7,766	6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 41,995	21

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	424,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	170,265	2
3. Under or (over) accrual (line 2 minus line 1).	$	(253,735)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	445,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	27,053	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	218,518	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998	106,522	11
1999	174,076	12

2000 accrual based on attorney letter ($424,000 x 105% = $445,200)

Taxes paid $174,076 + Care Center Allocation $1,801 - Dr. Office $5,612 = $170,265

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,467 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Doctor's Office - 2859 square feet (related assets included with non-care on page 13, and expenses adjusted out on page 5)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 115,447
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 12,710
4. Dates Incurred:

Nature of Costs: Closing Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 400,000	1
2	Alloc from CCI			2,067	2
3	TOTALS			$ 402,067	3

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	232		1998	1998	$ 11,806,343	$ 302,727	35	$ 590,317	$ 287,590	$ 1,672,565	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLING			1998	4,200	108	20	210	102	473	9
10	SPRINKLER SYS.			1998	900	23	20	45	22	116	10
11	CABLING			1998	4,410	113	20	221	108	589	11
12	ELECTRICAL RENOV			1998	695	18	20	35	17	93	12
13	PAINT/WALLPAPER			1998	1,603	41	20	80	39	213	13
14	CABLING			1998	2,520	65	20	126	61	347	14
15	CABLING			1998	6,920	177	20	346	169	836	15
16	CABLE/WIRING			1998	3,476	89	20	174	85	493	16
17	LANDSCAPING			1998	28,875	740	20	1,444	704	3,008	17
18	AVIARY SET-UP			1998			20				18
19	CABLING			1998	635	16	20	32	16	83	19
20	CABLING			1998	5,945	152	20	297	145	693	20
21	CABLING			1998	1,415	36	20	71	35	148	21
22	FENCING			1998	4,062	104	20	203	99	457	22
23	SIGN UPGRADE			1998	2,195	56	20	110	54	248	23
24											24
25	PAGE 12-1 REP TOTALS				164,146	4,254		7,434	3,180	22,861	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				11,541	220		452	232	452	33
34	PAGE 12B TOTALS				39,243	1,171		1,427	256	1,991	34
35	PAGE 12A TOTALS				68,260	2,633		3,412	779	6,353	35
36	TOTAL (lines 4 thru 35)				$ 12,157,384	$ 312,743		$ 606,436	$ 293,693	$ 1,712,019	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LOGO DESIGN			1998	1,275	33	20	64	31	181	9
10	CUBICLE CURTAIN			1998	595		20	30	30	83	10
11	CUBICLE CURTAINS			1998	884	163	20	44	(119)	103	11
12	SCONCE			1998	684	126	20	34	(92)	79	12
13	CHANDELEIR			1998	1,089	201	20	54	(147)	126	13
14	LANDSCAPING			1998	2,744		20	137	137	365	14
15	CABLING			1998	1,505	39	20	75	36	156	15
16	SIGN			1998	1,000	26	20	50	24	121	16
17	FENCING			1998	4,062	104	20	203	99	508	17
18	CABLING			1998	3,368	86	20	168	82	420	18
19	TV CABLE			1998	6,240	160	20	312	152	832	19
20	LANDSCAPING			1998	2,958	76	20	148	72	308	20
21	TV CABLE			1998	2,905	74	20	145	71	375	21
22	PHONE WIRING			1999	936	24	20	47	23	59	22
23	CABLING			1999	1,596	41	20	80	39	107	23
24	PHONES			1999	1,320	422	20	66	(356)	94	24
25	VACUUM PUMP			1999	540	173	20	27	(146)	52	25
26	ELECTRICAL UPGRADE			1999	8,000	205	20	400	195	467	26
27	OXYGEN LINES			1999	980	25	20	49	24	61	27
28	COVE BASE			1999	1,570	40	20	79	39	105	28
29	WALLPAPER			1999	885	23	20	44	21	70	29
30	PLUMBING RENOV			1999	676	17	20	34	17	45	30
31	FIRE ALARM PANEL			1999	1,436	37	20	72	35	108	31
32	CABLING			1999	1,535	39	20	77	38	141	32
33	CABLING			1999	749	19	20	37	18	40	33
34	CABLING			1999	863	22	20	43	21	82	34
35	PLUMBING RENOV			1999	17,865	458	20	893	435	1,265	35
36	TOTAL (lines 4 thru 35)				$ 68,260	$ 2,633		$ 3,412	$ 779	$ 6,353	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLING			1999	1,000	26	20	50	24	71	9
10	MOTOR			1999	3,085	79	20	154	75	231	10
11	DRAPES			1999	1,023	26	20	51	25	81	11
12	VACUUM PUMP PIPING			1999	1,000	26	20	50	24	100	12
13	FIRE SYSTEM UPGRADE			1999	10,000	256	20	500	244	875	13
14	CABLING			1999	525	13	20	26	13	37	14
15	TELEPHONE WIRING			2000	592	3	20	8	5	8	15
16	PIPING - WATER HEATR			2000	2,680	14	20	34	20	34	16
17	PAINT			2000	846	5	20	11	6	11	17
18	TELEPHONE CABLING			2000	1,335	18	20	39	21	39	18
19	TELEPHONE WIRING			2000	749	4	20	9	5	9	19
20	PLUMBING RENOV			2000	1,137	21	20	43	22	43	20
21	BOILER REPAIR			2000	770	154	20	26	(128)	26	21
22	VENT REPAIR			2000	658	132	20	22	(110)	22	22
23	VENT REPAIR			2000	587	118	20	20	(98)	20	23
24	TELEPHONE CABLING			2000	749	6	20	12	6	12	24
25	TELEPHONE CABLING			2000	1,498	14	20	31	17	31	25
26	HEAT ELEMENT			2000	658	9	20	19	10	19	26
27	BOILER REPAIR			2000	503	101	20	17	(84)	17	27
28	OUTLETS			2000	1,125	18	20	37	19	37	28
29	HVAC			2000	1,101	15	20	32	17	32	29
30	HVAC			2000	1,418	14	20	30	16	30	30
31	TELEPHONE CABLING			2000	582	9	20	19	10	19	31
32	TELEPHONE WIRING			2000	656	4	20	8	4	8	32
33	TELEPHONE CABLING			2000	1,598	32	20	67	35	67	33
34	FIRE PANEL			2000	2,608	42	20	87	45	87	34
35	WIRING			2000	760	12	20	25	13	25	35
36	TOTAL (lines 4 thru 35)				$ 39,243	$ 1,171		$ 1,427	$ 256	$ 1,991	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING RENOV			2000	960	18	20	36	18	36	9
10	CEILING MOUNT			2000	1,100	22	20	46	24	46	10
11	CEILING MOUNT			2000	859	17	20	36	19	36	11
12	HVAC			2000	815	17	20	34	17	34	12
13	SINAGE			2000	514	10	20	22	12	22	13
14	TELEPHONE CABLING			2000	1,740	36	20	73	37	73	14
15	TELEPHONE CABLING			2000	796	18	20	37	19	37	15
16	TELEPHONE CABLING			2000	656	16	20	33	17	33	16
17	FIRE ALARM PANEL			2000	688	17	20	34	17	34	17
18	SPRINKLER UPGRADE			2000	1,250	31	20	63	32	63	18
19	PAINT			2000	1,460	8	20	18	10	18	19
20	TELEPHONE CABLING			2000	703	10	20	20	10	20	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,541	$ 220		$ 452	$ 232	$ 452	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996	Alloc - CCI	$ 36,580	$ 938	35	$ 1,045	$ 107	$ 4,268	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from Care Centers, Inc.			2000	44	1	20	2	1	2	9
10	Allocated from Care Centers, Inc.			1999	655	17	20	33	16	62	10
11	Allocated from Care Centers, Inc.			1998	270	7	20	14	7	36	11
12	Allocated from Care Centers, Inc.			1997	3,837	88	20	212	124	1,025	12
13	Allocated from Care Centers, Inc.			1996	4,217	56	20	203	147	697	13
14	Allocated from Care Centers, Inc.			1997	445	103		19	(84)	43	14
15	Allocated from Care Centers, Inc.			1994		12	20		(12)		15
16	Allocated from Care Centers, Inc.			1993		4	20		(4)		16
17											17
18											18
19	Theater			1998	78,828	2,021	20	3,941	1,920	11,166	19
20	Grout Work - BLDG Partnership			1998	599		20	30	30	85	20
21	Flooring - BLDG Partnership			1998	1,500		20	75	75	213	21
22	Plumbing - BLDG Partnership			1998	2,908		20	146	146	413	22
23	Cabling - BLDG Partnership			1998	900		20	45	45	128	23
24	Flooring - BLDG Partnership			1998	1,350		20	68	68	193	24
25	Sign - BLDG Partnership			1998	32,013	1,007	20	1,601	594	4,530	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 164,146	$ 4,254		$ 7,434	$ 3,180	$ 22,861	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FC # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,259,421	$ 268,024	$ 126,199	$ (141,825)		$ 357,691	37
38	Current Year Purchases	15,942	3,141	787	(2,354)		787	38
39	Fully Depreciated Assets		95		(95)			39
40								40
41	TOTALS	$ 1,275,363	$ 271,260	$ 126,986	$ (144,274)		$ 358,478	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Allocated from Care Center, Inc.			$ 17,375	$ 3,764	$ 2,680	$ (1,084)	10	$ 6,015	42
43										43
44										44
45										45
46	TOTALS			$ 17,375	$ 3,764	$ 2,680	$ (1,084)		$ 6,015	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 13,852,189	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 587,767	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 736,102	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 148,335	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,076,512	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Vacant Land - 1999	$ 55,211	$	$	52
53	Dr. Office - 1998	527,554	13,527	37,763	53
54					54
55					55
56					56
57	TOTALS	$ 582,765	$ 13,527	$ 37,763	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK
0043778
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
Pavilion of Forest Park	57,985	14,537	5,804	(8,733)	11,694
Forest Park Property LLC	1,170,414	224,720	117,041	(107,679)	331,616
Care Centers Inc	31,022	4,013	3,354	(659)	14,381
Ventlease LLC		24,754		(24,754)	
TOTALS	1,259,421	268,024	126,199	(141,825)	357,691

LINE 29: CURRENT YEAR

Pavilion of Forest Park	14,194	2,841	746	(2,095)	746
Forest Park Property LLC					
Care Centers Inc	1,748	300	41	(259)	41
Ventlease LLC					
TOTALS	15,942	3,141	787	(2,354)	787

LINE 30: FULLY DEPRECIATED

Pavilion of Forest Park		95		(95)	
Forest Park Property LLC					
Care Centers Inc					
Ventlease LLC					
TOTALS		95		(95)	

TOTALS (Should Tie to Totals on Page 13)

Pavilion of Forest Park	72,179	17,473	6,550	(10,923)	12,440
Forest Park Property LLC	1,170,414	224,720	117,041	(107,679)	331,616
Care Centers Inc	32,770	4,313	3,395	(918)	14,422
Ventlease LLC		24,754		(24,754)	
TOTALS	1,275,363	271,260	126,986	(144,274)	358,478

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST P./# 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Care Center				3,445			5
6								6
7	TOTAL				$ 3,445 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 10,914 Description: see attached
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 89,802	$		$ 89,802	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			20,068			20,068	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			119,791			119,791	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				149,964		149,964	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1		195,558					195,558	12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					186,472		186,472	13
14	TOTAL			$ 195,558		$ 229,661	$ 336,436		$ 761,655	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	34,137
2	Air Fluidized Beds	43,455
3	Lab	3,091
4	Enteral	7,783
5	Respiratory Therapy Supplies	70,769
6	Radiology	3,287
7	Ambulance	791
8	Ventilator Equipment Rental	21,660
9	Medical Equipment Rental	1,499
10		
		186,472

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST P# 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,510	$ 36,004	1
2	Cash-Patient Deposits	25,510	25,510	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,212,219	2,212,219	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,036	3,036	6
7	Other Prepaid Expenses	9,759	9,759	7
8	Accounts Receivable (owners or related parties)	868,620	672	8
9	Other(specify): See supplemental schedule	(24,338)	(24,338)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,102,316	$ 2,262,862	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		455,211	13
14	Buildings, at Historical Cost		12,412,725	14
15	Leasehold Improvements, at Historical Cos	177,750	217,019	15
16	Equipment, at Historical Cost	78,572	1,248,986	16
17	Accumulated Depreciation (book methods)	(47,653)	(1,772,317)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		115,447	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(12,710)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	3,397	3,397	22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 212,066	$ 12,667,758	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,314,382	$ 14,930,620	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 433,476	$ 433,476	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,679	24,679	28
29	Short-Term Notes Payable	4,093,585	4,093,585	29
30	Accrued Salaries Payable	165,852	165,852	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,288	24,288	31
32	Accrued Real Estate Taxes(Sch.IX-B)	445,200	445,200	32
33	Accrued Interest Payable	10,800	10,800	33
34	Deferred Compensation	985	985	34
35	Federal and State Income Taxes	(38,850)	(38,850)	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	450	2,717,195	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,160,465	$ 7,877,210	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		10,434,597	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 10,434,597	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,160,465	$ 18,311,807	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,846,083)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,314,382	$ #REF!	48

*(See instructions.)

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST # 0043778 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	(24,338)	(24,338)
	(24,338)	(24,338)

OTHER NON CURRENT ASSETS:

OTHER CURRENT LIABILITIES:	Amount	Amount
Due to Hunter Management		2,716,745
Deferred Taxes	450	450
	450	2,717,195

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,969,310)	1	
2	Restatements (describe):		2	
3	**Schedule attached**	102,000	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,867,310)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	21,227	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 21,227	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,846,083)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	FOREST PARK L.L.C. D/B/A PAVILI(#	0043778	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(1,867,310)
Adjustments:		
		-
		-
		-
To recored amount due from members for capital. (1999 late AJE)		(102,000)
Total adjustments		(102,000)
Balance - Beginning of Year		(1,969,310)
Equity(Deficit) from Page 17 Col 1		(1,846,083)
Related Party		
Equity(Deficit)	-1028355	
Income	-506749	
		(1,535,104)
Combined Equity - End of Year		(3,381,187)

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FO # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,949,588	1
2	Discounts and Allowances for all Levels	(1,450,351)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,499,237	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,125,440	6
7	Oxygen	37,315	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,162,755	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	55	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	120,068	16
17	Sale of Drugs	148,406	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,707	19
20	Radiology and X-Ray	5,378	20
21	Other Medical Services	634,524	21
22	Laundry	980	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 937,118	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	82,420	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 82,420	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,679	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,679	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,684,209	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,047,483	31
32	Health Care	2,632,649	32
33	General Administration	1,482,070	33
	B. Capital Expense		
34	Ownership	1,611,725	34
	C. Ancillary Expense		
35	Special Cost Centers	761,687	35
36	Provider Participation Fee	127,368	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,662,982	40
41	**Income before Income Taxes (line 30 minus line 40)****	21,227	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 21,227	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **FOREST PARK L.L.C. D/B/A PAVI # 0043778** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION		AMOUNT
1	Miscellaneous Income	(adjusted out on page 5)	200
2	Jury Duty Income	(adjusted out on page 5)	17
3	Misc. Private Revenue		737
4	Misc. Cash Receipts	(adjusted out on page 5)	785
5	Voided Check - Legal	(adjusted out on page 5)	940
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
		TOTALS	2,679

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PA # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	4,878	5,609	135,834	24.22	2
3	Registered Nurses	5,051	5,699	116,541	20.45	3
4	Licensed Practical Nurses	42,514	46,869	859,310	18.33	4
5	Nurse Aides & Orderlies	80,289	89,510	779,752	8.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,609	10,576	195,558	18.49	7
8	Rehab/Therapy Aides	5,543	5,966	76,842	12.88	8
9	Activity Director	1,548	1,740	22,869	13.14	9
10	Activity Assistants	12,361	12,945	88,194	6.81	10
11	Social Service Workers	2,491	2,637	35,892	13.61	11
12	Dietician	974	1,151	13,506	11.73	12
13	Food Service Supervisor	1,915	2,340	36,783	15.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,496	20,789	155,907	7.50	15
16	Dishwashers					16
17	Maintenance Workers	4,403	4,833	71,894	14.88	17
18	Housekeepers	18,178	19,097	128,820	6.75	18
19	Laundry	6,787	7,308	49,883	6.83	19
20	Administrator					20
21	Assistant Administrator	2,177	2,269	31,500	13.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,352	9,360	101,296	10.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,901	2,127	22,550	10.60	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	227,467	250,825	$ 2,922,931 *	$ 11.65	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	255/monthly	$ 18,628	1-3	35
36	Medical Director	monthly	30,000	9-3	36
37	Medical Records Consultant	monthly	4,704	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	4,195	10-3	39
40	Physical Therapy Consultant	45	2,225	10A-3	40
41	Occupational Therapy Consultant	32	1,588	10A-3	41
42	Respiratory Therapy Consultant		987	10A-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,063	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	CCI costs	see attached	103,102		48
49	TOTAL (lines 35 - 48)	121	$ 167,492		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	347	$ 14,139	10-3	50
51	Licensed Practical Nurses	1,712	51,183	10-3	51
52	Nurse Aides	8,723	152,972	10-3	52
53	TOTAL (lines 50 - 52)	10,782	$ 218,294		53

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FO # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrator salaries directly allocated from HO (see page 6)			$
Diane Hart	Asst. Admin.	0	31,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 31,500

B. Administrative - Other

Description	Amount
Chris Wayer - management fees	$ 12,195
CCI Administrator payroll (adjusted on page 6)	65,489
TOTAL (agree to Schedule V, line 17, col. 3)	$ 77,684
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Deutsch, Levy & Engel	RE Tax Appeal	$ 27,053
Lawrence Schwartz	Legal	1,480
Frost, Ruttenberg & Rothblatt	Accounting	10,200
Alpha Data Services	Computer Services	4,833
Maxsourse	Computer Services	1,000
Sourcetech	Computer Services	1,380
Briggs	Computer Services	55
Personnel Planners	Unemployment Consultant	1,942
Genesis Health Services	JCAHO Consultant	971
Care Centers, Inc.	various - see attached	324,570
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 373,484

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,811
Unemployment Compensation Insurance	66,205
FICA Taxes	221,699
Employee Health Insurance	83,808
Employee Meals	7,613
Illinois Municipal Retirement Fund (IMRF)*	
Pension	27,765
Misc. Employee Benefits	3,027
TOTAL (agree to Schedule V, line 22, col.8)	$ 475,928

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	31,661
Health Care Worker Background Check	2,064
(Indicate # of checks performed 172)	
Licenses and Fees	1,760
Placement Fees	3,300
Dues & Subscriptions	11,710
Advertising & Promotion	20,595
Yellow Page Advertising	1,070
Allocated from Care Center	1,093
Less: Public Relations Expense	( )
Non-allowable advertising	(20,595)
Yellow page advertising	(1,070)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,788

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,916
Educational Materials	2,011
Allocated from Care Center	3,864
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,791

**See instructions.

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST P # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FOREST PARK L.L.C. D/B/A PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **CNA only**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council of Long Term Care $6979**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,187** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **127,368**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **see page 11** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **7,613** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **55**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **none**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw